

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

8867-62-036624
STATE FILE NUMBERDO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8867

FILED SEP 24 1962

VS 300
Rev. 4/59

1

2 40313

3

4 0

5 2

6

7 1

8 1

9

10

11

12 59-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK
OR
TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 12 hours		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		c. CITY OR TOWN Normandy		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5576 Norway Dr.				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OTTO Middle F Last RENNER						4. DATE OF DEATH Month September Day 11 Year 1962					
5. SEX male		6. COLOR OR RACE white		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10/13/1882		9. AGE (last birthday) 79 years		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plant supt.				10b. KIND OF BUSINESS OR INDUSTRY steel		11. BIRTHPLACE (City and state or country) Belleville, Illinois				12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Michael Renner				13b. MOTHER'S MAIDEN NAME Minnie Abel				14. NAME OF HUSBAND OR WIFE Laura E. Renner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. [redacted]		17. INFORMANT Charles Renner-29 Thorndell					
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aortic aneurysm DUE TO (b) Atherosclerotic Heart Disease DUE TO (c) 4:51 X Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) none								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION				COUNTY		STATE	
21. I attended the deceased from 9-5-65 to 9-11-62 and last saw him alive on 9-11-62 Death occurred at 9-11-65 3:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) William Leichter MD						22b. ADDRESS 3529 Ashland			22c. DATE SIGNED 9-13-65		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Sept 14, 1962		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis		23e. STATE Missouri			
24. FUNERAL DIRECTOR BUCHHOLZ MORTUARY-5967 W. Florissant Ave						25. DATE RECD. BY LOCAL REG. SEP 13 1962		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ralph C. Linders

Licensed Embalmer No. 4275

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.